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WAGE LOSS VERIFICATION

NAME OF EMPLOYEE:_____

NAME OF COMPANY:_____

ADDRESS: _____

TELEPHONE NO.: _____

EMPLOYEE'S HOURLY WAGE OR SALARY:_____

AVERAGE NUMBER OF HOURS WORKED PER WEEK: _____

TOTAL NUMBER OF HOURS MISSED FROM WORK: _____

EXACT DAY(S) OR PARTIAL DAY(S) MISSED DUE TO INJURY:_____

_____

_____

DATE EMPLOYEE RETURNED TO WORK ON A FULL TIME BASIS:_____

ANY OTHER RELEVANT INFORMATION: _____

_____

_____

_____
SIGNED: SUPERVISOR OR H.R. REP.

_____
PRINT NAME: SUPERVISOR OR H.R. REP.

_____
TITLE